U.S. ARMY SERVICE FORCES
SECOND SERVICE COMMAND

ENGLAND GENERAL HOSPITAL * CONVALESCENT FACILITY
Atlantic City, New Jersey

Proc. Reconditt. Conf., Atlantic City

Atlantic City

P R O C E E D I N G S

RECONDITIONING CONFERENCE

Classes I and II Trainees

Tuesday, 25 April 1944

ENGLAND GENERAL HOSPITAL * CONVALESCENT FACILITY
Atlantic City, New Jersey

RECONDITIONING CONFERENCE
Classes I and II Trainees
Tuesday and Wednesday, 25 and 26 April 1944

PROCEEDINGS
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PRESIDING: Lt. Col. L. C. Duryea, MC, Director of Reconditioning, Second Service Command.

LT. COL. DURYEA: Gentlemen, we will come to order please. It looks very much as though Atlantic City is going to do us very well today. I think the sun will come out. The indorsement I wrote to high authorities is having effect. Today we will observe the Convalescent Facility activities in Classes I and II. Not all patients stationed at general hospitals require further reconditioning as provided in Classes I and II of the Reconditioning Program. Surgeons of hospitals must carefully select the trainees that are to be put in Classes I and II of the program, such as those patients who require further reconditioning other than that which can be carried out at station and general hospitals. These hospitals are necessarily limited in personnel available who are qualified to furnish the necessary instructions and specialized physical training which is available at the Convalescent Facility for Class I and II patients, such as England General Hospital. Such personnel it seems are those centralized in installations of the sort you are to observe today. It must be remembered while you are here that the men you will observe are patients under medical care, and every activity in which they participate was suggested by Medical Officers for a specific purpose. You will hear more of this later. Some patients arriving here offer serious problems in orientation and morale. They have either been misinformed as to what to expect, or told of the heavenly retreat with pulchritudinous females strolling the boardwalk, and they would do nothing but enjoy life. But--they are wrong! We will note today the essential difference between Class III and IV and Class I and II activities, namely, increased physical activity. When you return to your station, it is desired that the persons interested in the reconditioning program be informed what is done here for them, and the reason, and what they may expect. The purpose of reconditioning is to return men to duty.

Colonel McDonald, Commanding Officer of England General Hospital and his staff have demonstrated the use of the Convalescent Facility as an aid to the conservation of man-power. It gives me great pleasure to introduce Colonel Robert C. McDonald. Colonel McDonald:

ADDRESS OF WELCOME AND INTRODUCTION
OF DISTINQUISHED OFFICERS

By

Col. Robert C. McDonald, MC,
Commanding Officer, England
General Hospital

COLONEL McDONALD: General Hillman, Colonel Scott, Colonel Duryea, Colonel Walson and fellow Officers, we are very pleased to have officers interested in the Reconditioning Program meet here at the Convalescent Section of the England General Hospital to see something of the reconditioning of Class I and II patients in progress. We expect to gain a good deal of value out of your comments and observations. We hope you will find that we have attained a fair degree of accomplishment in convalescent training and that we are in a position to make further satisfactory progress in the future. It has been our pleasure to study the proceedings of the reconditioning conference at the Schick General Hospital held last month in Iowa. We got many helpful suggestions from those proceedings. We shall be glad to have an account of your observations and proceedings at Halloran General Hospital yesterday.

I believe that the England General Hospital Convalescent Service is the first large installation of the sort established by the Army Service Forces in this country. Notice, I refer to it as Convalescent Service. Everyone seems to have his own idea of what we shall call these facilities: Services, Sections, etc. I am preaching rather than practicing at the moment. I prefer to call it the Convalescent Facility of the England General Hospital. You will note in War Department Circular No 140 that the independent Convalescent Reconditioning Facility is to be called a Convalescent Hospital from now on rather than a Convalescent Center.

Last fall, the Surgeon General selected Colonel A. O. Haff, MC, an officer especially qualified in training and organization work, to plan and organize the Convalescent Section of England General Hospital. During the period 15 October 1943 to 15 March of this year, Colonel Haff wisely and energetically carried out his mission. Prior to 10 December, all patients of the Convalescent Section were quartered in the Chalfonte Hotel adjacent to the main hospital in Haddon Hall. On that day, all the patients undergoing reconditioning, except the neuro-psychiatric cases, were moved into the Traymore Hotel here. Neuro-psychiatric patients undergo reconditioning at the Chalfonte Hotel under supervision of the Director of the Mental Hygiene Unit. During the early days, work was hampered to a considerable extent by renovation of buildings, lack of equipment, etc. Much of our equipment is home-made.

Last month, Colonel Raymond F. Scott, MC, was selected by the Surgeon General to succeed Colonel Haff as Reconditioning Officer at England General Hospital. This was done in order to make Colonel Haff available for important overseas assignment, also to place at the head of the reconditioning work an officer with recent overseas service. Colonel Scott is carrying on the work in a highly satisfactory manner.

The Convalescent Section of England General Hospital has a capacity of approximately 2500 patients. We have never had over 752 I's and II's under training at one time. Facilities are available for the care of Groups I and II patients from hospitals having a total patient load of 12,000 to 15,000. Naturally, the capacity of the Convalescent Section greatly exceeds the needs for the reconditioning of patients transferred into it from England General Hospital proper. We have received, under the direction of Colonel Walson, many patients from various general and station hospitals in the Second Service Command. We may receive certain classes of patients from the First and Third Service Commands, if present plans materialize. Eventually, we may receive large numbers of patients directly from debarkation hospitals and ports. We could, if necessary, direct certain types of Group III in our Convalescent Section.

We have a loyal, efficient group of officers, enlisted men, and civilians on duty in the Convalescent Section. Generally speaking, the patients appreciate what is being done for them and cooperate in the program. We are sure we will profit greatly by suggestions we receive from you after you have seen what we are doing. We hope you will find much of interest to you in the work here. We welcome you, and shall seek to make your stay a pleasant one. We hope you will be able to attend our Dedication exercises next Friday afternoon. We expect to have a number of distinguished speakers from Washington and other places. Before I leave the stand, I believe we have joined with us here in Atlantic City some distinguished participants from Washington. I would like to introduce them at this time. General Charles G. Hillman, Director of Professional Services in The Surgeon General's Office. Also we have from Washington a representative of G 1, Colonel Frank Barnes. A representative from G 3, Colonel Blake. I want you all to get acquainted with the various representatives. We are again very pleased to have you with us and hope that your stay will be an interesting and pleasant one, and that you will benefit a great deal from it. Thank you.

Col. L. C. DURYEA: The next speaker will be a man we all know. He spoke to us yesterday in the rain at Halloran General Hospital. Col. C. M. Walson, Second Service Command.

PURPOSE OF CONFERENCE, ACTIVITIES
TO BE OBSERVED
BY
Col. C. M. Walson, MC, Surgeon
Second Service Command

Col. WALSON: Undoubtedly you will say that I did a little exaggerating and bragging yesterday about the weather, about England General Hospital and about the wonderful climate here in Atlantic City. Not at all, that is not the case. Col. Mc Donald and Col. Scott arranged this whole matter yesterday; arranged the weather as well as the other details you will enjoy. I have known them both a long while - they are great fixers. I never expected to have the experience of being met at the train in Atlantic City and escorted up the boardwalk in an automobile. I thought that was sacrilegious. So don't feel that I was bragging or misrepresenting the weather. It had all been arranged beforehand.

A few days ago when I was talking about the climate in Atlantic City, some of the people in my office wondered if I had heard the story about the Californian who had been asked to speak, as he was a friend of some deceased individual. This is the tale of a traveling salesman. When he got up to speak at the funeral service, he began his remarks by saying, "Before I speak about the deceased, I would like to talk for a bit about the wonderful climate of California."

In my remarks applying to the weather I am pretty close to the written remarks I have made because speaking extemporaneously to me is out of the question, so much so that I have to read the Lord's prayer every night; I can't memorize it.

During the past year, about once a month I have visited Atlantic City. The contrast in the climate in summer or winter between here and New York City is remarkable. Atlantic City has been for years the most popular summer and winter resort in this section of the country. Annually, every month of the year, thousands of visitors within a radius of many hundred miles come here to enjoy the invigorating climate, the bathing, and other recreational facilities. England General Hospital, with its Convalescent Facility, is most favorably located here where there is a combination of an ideal temperate climate and plenty of sunshine and fresh salt sea air, free from soot and dust.

Our patients in the reconditioning center are divorced from a hospital atmosphere and this is a valuable adjunct in their convalescence. I cannot conceive a better place, which is in close proximity to dense population, more admirably suited for carrying out our reconditioning program for Classes I and II patients.

The importance of reconditioning cannot be over-emphasized. General Kirk, The Surgeon General, U.S. Army, was long ago indoctrinated with the merits of reconditioning patients. For many years following World War I, he headed the orthopedic service at Walter Reed General Hospital. It has been said that he has had more experience in post-war orthopedic surgery than any other physician in the United States. Certainly no one individual has had more to do with the advances made in salvaging our soldiers since World War I. At the time he was doing so much for our soldiers, I was on duty at Walter Reed General Hospital and vividly recall his tireless efforts and great accomplishments. With his vast experience and psychological approach to the problems in reconditioning it should be expected that he would lead the way today in our reconditioning program. At his first conference held for Service Command Surgeons shortly after taking his oath of office as Surgeon General, he stressed in no uncertain terms his program of reconditioning and, as we all know, ever since has grasped any opportunity to emphasize the importance of reconditioning patients. Knowing his bulldog tenacity in carrying through a worthy project once instituted, it behooves us all in the Medical Department to follow our leader in this most worthy cause. I have no doubt that after this war the physical and mental reconstruction of soldiers through modern reconditioning will be considered one of the most outstanding accomplishments of the Medical Department.

The last World War gave Physiotherapy and Occupational Therapy their places in medicine. We made one serious mistake keeping patients in the hospital too long. The full import of reconditioning was not fully recognized. We saw only part of the picture. The various phases of reconditioning, its immediate need after disability, its continuation throughout the hospitalization period, the psychological value of removing a patient from the hospital atmosphere was often lacking.

The ultimate aim of the Medical Corps is to restore the patient to his proper place in the war effort and, whenever possible, to make him able and ready to carry on his former duties and responsibilities. This is what the Army has a right to expect from us and this is what we must do. All too often, the patient has been skillfully lead and started on his journey toward complete restoration to health and strength, only to be deserted before the end of the road is reached. It is because it is to the interest of the Army and to the patient to carry on until the ultimate goal of restoration is reached, that this conference on reconditioning is being held.

The program of this Convalescent Facility necessarily includes many varied activities in order to meet the particular needs of soldiers recovering from many different types of conditions. Proper professional supervision must be maintained while these men are being toughened physically by graduated exercise. Special effort must be made to overcome the psychology of invalidism. We must instill in each of our patients the will to recover completely and to be of service. We must foster an aggressive fighting spirit.

In the relatively few months that have elapsed since this program has been initiated at the England General Hospital, gratifying progress has been made.

In the months to come, we must be prepared to care for a greatly increased number of patients from overseas - a number which will tax our facilities in the station and general hospitals. The transfer of suitable patients from our station and general hospitals will enable us to utilize the professional and physical facilities of those installations for the care of the acutely sick. This will effect a saving, not only of our physical equipment, but will also greatly assist us in meeting the heavy professional demands on our medical officers by using them to care for those patients who actually require constant professional supervision. The facilities here at Atlantic City are excellent for this purpose.

Today you will observe the activities of reconditioning for Classes I and II patients. Many of you have been confused as to the entrance requirements to Class II activities. We expect the confusion will be dissipated today.

Many patients who arrived here formerly were not actually soldiers. They had lost contact with the Army, they did not act, talk or think like soldiers. To fit them for the Army again necessitated beginning with basic instruction in military training, education and indoctrination. Patients arriving now are in a somewhat better military status due to their having participated in Class III and IV activities at station and general hospitals. It is essential that patients in our hospitals be made to realize, by proper indoctrination and training in military subjects, that they are soldiers. The sooner you can get convalescent patients out of pajamas and bathrobe and into uniform and under military discipline, the sooner they again become soldiers.

It is necessary to get these men back to duty as soon as is consistent with adequate medical care. A soldier is a patient as long as he is in hospital clothes. As soon as he is in uniform he again becomes a soldier -- and no sooner. The job of the hospitals is not to make patients, but to treat sick or injured soldiers. Treat the convalescents as patients and you will keep your beds occupied. Treat them as soldiers and they will respond. The program of reconditioning should serve to empty your hospitals of all except the acutely ill and early convalescent patients.

I feel certain that through this conference, we shall understand our problems more clearly and that our plan of action, enthusiastically and conscientiously followed, will result in a highly successful program of reconditioning and the early return of more soldiers to full military duty in the best possible physical and mental condition.

COL. DURYEA: The Director of the Convalescent Facility of England General Hospital is Colonel Scott, who will speak on reconditioning of patients. Colonel Scott:

RECONDITIONING OF CLASSES I AND II TRAINEES

By

Col. R. E. Scott, MC, Director, Convalescent Facility, England General Hospital

Most of you have just witnessed a very excellent program at Halloran General Hospital, at which time you were made acquainted with Classes III and IV activity. Here at England General Hospital, the Convalescent Facility will endeavor to make known to you the activities of Classes I and II Trainees and, as indicated in your schedule, none of the III and IV Classes will participate.

We have tried to arrange a well rounded schedule wherein you will become acquainted with our physical set-up while witnessing actual demonstrations. This program will keep all of you busy until Retreat. You have been placed in Groups to facilitate the following of the schedule since it is important that a strict time schedule be maintained. Each Group has a leader who will remain with it and explain briefly the various demonstrations.

It is our intention that this Conference be very informal and the Group Leaders will be glad to answer any questions that may occur to you. Please feel free to ask them.

Tomorrow morning will be devoted to the more formal talks, and in the afternoon there will be round table discussions when you may ask the many detailed questions that come to your mind as they apply to your own problems at your home stations. Following this we have arranged an open forum for total attendance, at which time we hope you will ask questions of such a broad nature that our distinguished guests may enlighten you to the over-all picture of the complete Reconditioning Program.

General Hillman has suggested that sometime between now and tomorrow at 1400, you indicate certain questions of a broad nature as pertaining to the reconditioning program, and these be left on your desks. They will be picked up and submitted to the officers best qualified to answer them at the open forum tomorrow afternoon. I must not give you that much time. Let us have them sometime this evening. Leave them on your desks before the evening activities are over. They will be submitted so that the officers can properly answer them tomorrow afternoon.

We hope your stay here will be a pleasant one. We are going to house you and feed you well. We have tried to anticipate your wants and needs. Every member of the Staff of the Facility stands ready to aid you.

The Convalescent Facility of England General Hospital has a bed capacity of 2600; 1800 in this, the Traymore Hotel, and 800 in the Chalfonte Hotel adjacent to Haddon Hall hotel. These beds are available for Classes I and II Trainees. In this hotel are housed all Trainees in Classes I and II, except those undergoing training in the Mental Hygiene Unit. The latter are housed in the Chalfonte Hotel.

The establishment of a Classes I and II program presupposes a well planned Class III and IV program in the Hospital. In the Hospital the sick and wounded are cared for and the convalescent period begins. In the past, this period has been fraught with monotony - very little or nothing to do. The Reconditioning Program aims to freshen a soldier mentally and physically and return him to duty in the best possible condition. The variety of activity and outdoor exercise are stimulating. This does not always appeal to the men at first, but soon the competitive spirit of the program becomes contagious and they participate to the extent their disabilities permit.

The aim of reconditioning is simply to develop within the individual the will to live; the will to overcome a disability happily and speedily; the re-education of muscles, tendons, joints, etc., so that the man can accomplish his mission in life as well as, if not better than, heretofore.

The soldier who permits his will to slacken to the point where he thinks he is a cripple, for example, will always be a cripple. The will to live means that a man will not tolerate the idea or meaning of the word "cripple". It is, of course, difficult for the man not to be weak when there is reconditioning work to be done. But once the will to live is firmly entrenched in his mind, the aches and pains become transient with the activities of the program. The limited activity of the injured part often seems to melt away, yielding to strong coordinated body parts that tend toward making the man what he normally was, despite the fact that he had been injured or sick.

Reconditioning helps the man to think as a man, not as a cripple or weakling. This makes for more rapid recovery and ingrains in the mind of the man the will to live as he would like to live and accomplish the work before him. It serves to return the man to duty and to finish the task that was originally interrupted by illness, accident or weapen.

The basic principle of Classes I and II reconditioning lies in the efficacy with which the man is divorced from the hospital environment. By putting the man in uniform and housing him in separate buildings, treating him as a soldier and not as a patient, and giving him the same privileges as Medical Department Detachment personnel, places him on his own initiative, with the result of gain in self respect. Housing in separate quarters makes necessary various types of police work which has a definite beneficent effect from the standpoint of physical repair. It is just another type of exercise that the man soon accustoms himself to perform.

A comprehensive program of activities is outlined for the men each week. Every portion of the time, from Reveille to Retreat, is concerned with some activity or educational work. The only exception to this is the lengthy noon hour in which a man can comfortably eat his dinner and nap, or indulge in self selected recreation.

Gymnasia have been established and are operated by qualified physical education directors who directly supervise the activities. Various types of exercises have been established. There are those exercises which aim to enhance body muscular tone. These particular exercises consist of calisthenics, drill and group games. A third group of exercises stimulate the competitive spirit. These are conducted on the beach or in the fields set aside for this work. They consist of games involving the competitive spirit such as volleyball, softball, basketball, horseshoe pitching, medicine ball routines, etc. Since all games are supervised and no man is permitted to stand idly by while these games are in progress, and since the games are rotated during a particular period, no man is beset with monotony. It has been found that many men will not enter games unless they are compelled to enter them. Games of this sort which depend upon the individual wish to play, result in stagnation and monotony. The man invariably likes to be told what to do. It has the same effect as a "Paul Jones" would have at a dance. It serves to integate the man into the spirit of the occasion. Gymnasia are well equipped with homemade physical educational apparatus. The mere fact that the apparatus is homemade does not mean that it is not efficacious. Apparatus has been developed that will suit the Reconditioning Program, and although much of the apparatus could have been purchased, time and lack of availability did not permit this to be done in view of the urgency of the Reconditioning Program.

A very important phase of reconditioning is orientation. It is most necessary that the men embrace reconditioning for all the advantages that it means. It means the reconstitution of muscles, joints and limbs, and the ability for men to live with residual disabilities or handicaps contentedly and happily. The fact that the individual has a disability does not mean that he will be a financial or moral load or responsibility on the part of the Government. His attitude is shaped by orientation so that he becomes willing and able to continue the war effort.

If proper screening is accomplished, no soldier will be sent to the I and II section (except in the Mental Hygiene Unit) who will be subject to CDD. We stress in our orientation the fact that all men here will go to some form of duty, their physical limitations only being the deciding factor.

Since the opening of the Convalescent Facility, a total of 3,478 cases have been admitted to the I and II section, and 2,453 cases have been returned to military duty in some capacity. The numerical difference is accounted for by the present load and certain cases transferred to other hospitals.

COLONEL BURNELL: The assistant Director of the Convalescent Facility of this Hospital is Major Arthur W. Fuchs who will speak of administration of the Reconditioning Program. Major Fuchs:

ADMINISTRATION OF A RECONDITIONING PROGRAM

BY

Major Arthur W. Fuchs, SnC, Assistant Director,
Convalescent Facility, England General Hospital

Administration of this Convalescent Facility is unique in that the duties of the personnel have evolved by reason of the peculiar requirements of a Reconditioning Program. The chain of command in its essence is identical to the usual Medical Department installation. Since the Convalescent Facility is a part of England General Hospital, yet physically separate, it was found advantageous to administer in their broader aspects the various operations in the same manner as a separate installation, although distinct departures from the usual were required.

The duties of the Director of the Convalescent Facility are analagous to that of a commanding officer and those of the Assistant Director, an executive officer. Our Administrative Assistant, is, in reality, an Adjutant. Due to the fact that all of the personnel records of the Trainees and permanent duty enlisted men are maintained at the Headquarters of the England General Hospital, much routine clerical work on our part has been eliminated. However, a Personnel Section has been found necessary to provide for the normal day to day administrative needs of the Facility. This Section is in charge of a 1st Lieutenant, MAC, who is under the direct supervision of the Administrative Assistant, a Captain, MAC. The Personnel Section also comprises a 1st Sergeant who is in direct charge of a group of Company clerks. All of these clerks work as a unit.

The various Trainee Companies are administered by one 1st Sergeant and two assistant Non-commissioned Officers. For administrative purposes, the Companies are divided into three battalions, each of which is commanded by a duty Officer, usually a 2nd Lieutenant, MAC. Each Company is officered by Trainee Officers who have no administrative functions, but do assist in the formations and ceremonies. Passes and furloughs of enlisted Trainees are approved by the Battalion Commanders.

The Inspector and Guard Officer is responsible for the maintenance of the hotel which involves all duties necessary for the proper sanitation, billeting, and fire protection of the installation. It is a most responsible position.

The functions of the Plans and Training Officer is to develop weekly and daily schedules of activities, both for enlisted and Officer Trainees. He is also responsible for the training program of that portion of the England General Hospital enlisted Detachment who are assigned to the Convalescent Facility. Coordination of all of these activities requires a considerable amount of attention and work.

The Morale and Special Services Officer occupies an important position in the Convalescent Facility. His job is to provide orientation lectures and discussions, recreation, and educational courses for the Trainees. An invaluable aspect for the success of a Reconditioning Program lies in the attitude that a Trainee assumes toward his reconditioning. If the man's mental attitude has not been properly oriented, his physical recovery is definitely delayed. It is here that this Officer should function superiorly.

Our Reconditioning Therapy Officer has direct supervision of all Physical Education Trainers; he is under the supervision of the Chief of Professional Services. The Physical Education Trainers are divided into three groups: (a) those who work in the gymnasia, (b) those who are attached to the Trainee Companies at all times, and (c) those who supervise all group games and athletics.

The gymnasia group is divided into two parts; one part confines its activities to Classes I and II Trainees in the Convalescent Facility, the other to Classes III and IV Trainees in the hospital proper.

The group assigned to the Companies devotes its time to close supervision of the physical activities of the Trainees. These men caution and encourage the Trainee with respect to his activities.

The game and athletic group plan and supervise indoor and outdoor games and athletics. These activities are closely supervised so that no man is ever idle. All games are described and there is no excuse for any man to plead ignorance of the activity as a means of avoiding participation.

A Reconditioning Program cannot afford to have its personnel changing if the duration of the Trainees' stay is to be consistent with the type of disability. Personnel have a dual duty. There is the normal administrative function and there is that intangible ability of personnel to act as shepherds of the flock, encouraging the men in their activities by a pat on the back or a cheerful word. These men must acquire the trust and confidence of the Trainees by a cheerful yet quietly authoritative manner. They cannot afford to be blustery, threatening or abusive. It must be remembered that many of the Trainees are freshly out of the hospital, they are sometimes weak and depressed. Cheerful, helpful attitudes on the part of the duty personnel are bound to be contagious. We know that rapid mental readjustment of the Trainee is dependent upon the actions of our personnel.

It is difficult to obtain and train men who have an innate aptitude for handling Trainees, and it is therefore most important that changes in personnel occur only to improve the training structure of the Facility.

There is one point in this connection that I would like to stress. Recognition should be made of the fact that many of our Trainees can provide excellent cadre men. They have been sick or wounded; they have been reconditioned; they have been through the "mill". Yet many, having residual disabilities, normally would be assigned limited duty upon departure from the Facility. In our organization, is it not possible for us to retain chosen enlisted Trainees for duty? Insofar as we are aware, no directive has been issued to cover such transfers.

Under Circular No 73, the procurement of Trainee Officers is authorized, yet there seem to be difficulties in procurement.

This Reconditioning Facility is capable of large scale reconditioning; yet, our Table of Organization has not been approved. This makes for some administrative difficulties since our personnel are carried as a part of the administrative structure of the England General Hospital that is based on 1750 bed capacity. The bed capacity of the Facility alone is 2,600 beds!

In closing, I wish to stress the necessity for maintaining an atmosphere of military duty within the Facility. Placing the Trainee in uniform and simulating a regular duty status is most effective in driving home the point that the man is still in the Army. Also that the man is no longer a patient and must therefore act as a man and a soldier, and helps over the transition between patient and ultimate duty. Therefore, strict discipline is maintained and the use of Courts Martial for fractious individuals is required. Observe the A.W.O.L-graph in our exhibit. It will be noticed that our A.W.O.L rate was high in December, 1943 and January, 1944. When strict disciplinary action was exercised, our A.W.O.L rate dropped as well as our restrictions as to pass privileges. We have found that we must be just, but we cannot afford to be too "soft". Thank you.

LT. COL. DURYEA: From time to time the War Department steals some of our good men. The Surgeon General's Office has recently taken lessons from the War Department, I'm afraid. Our next speaker is Captain Alva R. Dittrick, formerly the Director of Educational Reconditioning Plan of the Reconditioning Facility of England General Hospital, now attached to the office of the Surgeon General. It gives me great pleasure to introduce Captain Dittrick.

MORALE SERVICES OF A RECONDITIONING PROGRAM

BY

Capt. Alva R. Dittrick, AUS, Educational Reconditioning Branch, Reconditioning Division, Office of the Surgeon General

CAPT. DITTRICK: Upon considering morale as a factor of reconditioning, one becomes aware of the fact that there is no definite pattern existing for the services of the Special Services and Morale Divisions in the convalescent program. Through a statement of policy and guidance of Circular Letter 168, contacts with the Reconditioning Division of the Surgeon General's Office, a program of work was undertaken at the Convalescent Center. This paper is an attempt to relate the experiences of several months during the development of the Reconditioning Program for Classes I and II. From these experiences certain conclusions have been drawn and much of the program has been guided by these experiences. It has been recognized by the Commanding Officer and staff that a high degree of mental stamina is desirable and positive attitudes must be developed on the part of trainees if the reconditioning mission is to be achieved. Every aspect of the trainees' day becomes a factor in the building of morale: The medical service that he receives, the attitude of the duty personnel and relationships that develop. Quarters, supply, quality of mess, program of training, and recreational facilities all may effect positively or negatively the attitudes of the men. In considering morale as a factor in reconditioning four major areas will be noted:

1. Problems which existed at the time the present facility opened.
2. The program of educational reconditioning developed.
3. Evaluation of morale at this Convalescent Facility and
4. Recommendations and pertinent suggestions concerning morale as a factor in reconditioning.

At the time that this Facility opened on 10 December 1943, many problems presented themselves. One of the foremost was the question of personnel; another the slowness in procuring various types of equipment. It was a grand installation providing marvelous quarters and opportunities. However, much of the equipment necessary was lacking, and there was no immediate hope for procurement of such. This lack related to athletic equipment for games and sports, and various types of recreational equipment including ping pong tables, pool tables and games. Many of the services available from the Morale and Special Services Divisions were not being distributed. Requests were initiated and not much later results were noted. The attitudes of Trainees at this time presented another problem. It was observed that many bitter attitudes existed. Causes may be traced to a number of factors. One was the desire of the men for a CDD. Many had the feeling that they had been through the mill, done their part, and that they should go home. There was anxiety and inertia which, in many cases, resulted from months of hospitalization. There were many misunderstandings. Men came to the Convalescent Facility with the feeling that they were going to enjoy several weeks of resort life, hospital beds and all the comforts of a first class resort hotel, and they were chagrined when they found they were required to participate in a regular duty day and conform to military procedures. Many men objected to the program, as a result of having been inactive for a prolonged period, complaining it was too difficult. In addition there were personnel problems. Many of the duty personnel at the Convalescent Facility were not fully aware of the reconditioning mission. On the basis of these observations, a program was planned. It seemed wise to surround the men with abundant stimulating and challenging opportunities that would provoke as much participation by Trainees as possible. It was felt that through such a program, the minds might be diverted and responsibility for each individuals part in the successful prosecution of the war developed. This program was begun modestly. Three days each week problems and current phases of the war were presented by Duty Officers. Gradually patient officers were brought into the program as discussion leaders. Rather quickly the program developed until five days each week were devoted to a discussion of progress of the war and current world and domestic problems. These programs have been amazingly well received by the men. The Trainees are interested in the discussion of significant problems. Among the subjects which have been discussed are: the invasion, post-war plans for veteran education, the Argentine Question, and the Russian-Polish boundary dispute. In developing these discussions, sources of information material were essential. Orientation materials of Morale Services were regularly distributed. It was found that on the basis of the five day week program, these materials were inadequate. Other sources were discovered. Time, News Week, Fortune Magazine and USO publications cooperated wholeheartedly in supplying additional material.

An orientation library was developed. Sources of materials were newspaper clippings, pamphlets and magazine articles. This service was found particularly useful when trainee officers were asked to participate, for many became reluctant when they felt the program might involve long hours of preparation. When it was pointed out that this would not be the case, many were more eager to participate as discussion leaders. During this orientation period, one hour each day for all trainees, except for Company A, G. I. movies, various orientation films and other educational films are shown. The films have been supplied by the Morale Services, Visual Aid Section. Guest speakers have been scheduled. We have found the Atlantic City High School to be most cooperative in supplying services to the trainees of the Convalescent Facility. A series of lectures was established. Every 2 weeks, a member of the faculty spoke to the trainees on subjects of current interest. Contacts were made with the University of Pennsylvania. Arrangements have been made to begin in the near future, a series of programs by the faculty of the University, to supplement the orientation discussion programs. The War Writer's Board in New York City has indicated an interest and will schedule speakers and discussion leaders. Bulletin boards have played an important part in presenting orientation and information materials to the men. Examples of these bulletin boards can be seen at your right in the lecture hall. These bulletin boards for the most part were comprised of 3 parts: One section emphasizes the current daily war news. Copies are posted on bulletin boards on each floor. Current war newsmaps are posted and current developments of the war indicated by symbols. Each week a feature has been developed, examples of which you see to your right on the board. Among these features has been a series concerning the United Nations, giving the trainee a better understanding of the people and nations, with whom we are fighting.

As a part of the orientation and discussion program, the off-duty program of education as provided by the United States Armed Forces Institute was presented at regular intervals to these men. Considerable interest and concern has been indicated by many in their plans for the future. Each individual has been interviewed by an officer of the Morale Services concerning future educational plans. This was found to be particularly valuable, since many problems concerning the individual which may have caused anxiety and confusion, were often discovered. As a result of this conference, trainee problems could be referred to the proper officer in the administrative organization. The following factors indicate that substantial progress has been made as a result of the experiences related. Your attention is called to AWOL charts posted in the rear of the room. These charts will show that during the month of December there was a rate of AWOL's ranging from 20 to 30 and since that date there has been a gradual decrease. Since January it is well below an average of 5. Upon being returned to duty each trainee is asked to fill out a form which asks his evaluation of the Reconditioning Program. Samples are also posted on the Board at the rear. During the early weeks the pattern of remarks by the trainees were not complimentary. Recent weeks have shown marked improvement, although some are critical. Others are enthusiastic and express sincere appreciation. A suggestion box was placed on the lounge floor near the mail desk. During early weeks many suggestions almost entirely critical, were submitted. At the present time few suggestions are offered.

Originally, men were reluctant to participate or share in the various activities. Today, the athletic program finds most men eager to participate in group games and athletics. Real enthusiasm is evident. As group games and competitive sports were developed, tournaments were organized, prizes being awarded to the winners. Games were specifically selected, and adapted to each company depending upon the physical classification of the men. Competitive sports, basket ball, volley ball, shuffle board, ping pong, badminton and baseball appear to be the favorites.

Off-duty entertainment programs were poorly attended. At the present time a substantial number of the group attend movies shown two evenings each week. Other off-duty entertainment has been made available: Y. W. C. A., Stage Door Canteen, U. S. O. and other civilian organizations. At the outset men were indifferent to orientation programs and reluctant to participate in discussion. Their interest in current subjects has grown and at present the lively participation indicates improved attitudes. Returned overseas trainees have shown much greater cooperation and willingness to participate in the program.

The number of men restricted at present is much lower by contrast to the early weeks. The increasing frequency of the trainees who seek assignment to special duties may be judged as an indication of improved morale. Many of the men have inquired concerning the possibility of transfer to the Reconditioning Facility as permanent duty personnel. Sick call during the early weeks presented a problem. Each morning medical advisors were swamped with men reporting to sick call. The reduction of the number at present indicates increased interest in the program. These evidences of improved morale and better understanding may be traced to a number of causes. Sound administrative procedures, firm discipline, better understanding and coordination of services have caused greater cooperation on the part of trainees. Possibly no single factor has fostered improved attitudes and interest in the Reconditioning Facility than the initial orientation of trainees. Tuesday and Friday, a period of orientation is given to the new men who enter groups I and II. Several of the staff officers speak to the groups. A medical advisor, the personnel officer, plans and training officer and a representative of Morale Services serve as a panel to present the objectives of reconditioning and inform the men of rules, regulations and procedures. The purpose of this initial period of orientation is to anticipate any problems or questions the men have and to give them better understanding of their part in the program. An opportunity for questioning is provided and questions that may arise in the minds of the men may be answered on the spot. Following this discussion a film entitled "Life Begins Again", a British film portraying methods of rehabilitating injured and wounded, is shown. It is not ideally suited but it is the best available. It illustrates effectively the facts to put across to these men that the speed and extent to which they will recover use of that part of the body which is disabled, is going to depend not upon medical services alone, but the will of the man and necessity of participating in the program prescribed. I repeat, this one part of the program has been most important in better developing the men. It is felt that this mission of orienting the men to the Reconditioning Center of the program may well begin with groups III and IV patients. A well planned and firmly administered schedule results in desirable attitudes.

Coordination of all services is paramount. Trainees are quick to recognize confusion or lack of cooperation. Another aspect that has a considerable influence upon morale and the work in reconditioning, is the extent to which duty personnel understands their part in the reconditioning program. Aim to develop a pride in mission, and an appreciation of the part that each plays. Enthusiasm is contagious and the attitudes of duty personnel and officers has a great deal to do with the extent to which the men participate in the program. Photographs and graphically presented materials and well directed publicity is important. As an illustration we know that the child in school develops a pride in his organization upon seeing pictures of the Glee Club, football or basketball team or news stories concerning his school. Likewise, if the men who are training at a Reconditioning Center recognize that their work is receiving recognition, greater loyalty and pride is likely to grow. The hospital paper is important as a factor of morale. The ideal organization providing adequate personnel with abundant equipment may be slow to develop. However modest in the beginning, a program must be started, one must improvise and make the most of the resources that are at hand. That is undertaken must be approached in a sound manner. Require reasonable yet exacting standards of performance. The welfare of the trainee and attention to individual needs, must of necessity dominate the thoughts and actions of every officer and enlisted man in the Reconditioning Program.

COL. BUMILLA: Adequate medical supervision in every phase of the program is essential. Major Britt, Chief of the Professional Services will speak on the Reconditioning Program.

PROFESSIONAL SERVICES IN A RECONDITIONING PROGRAM

By

Maj. Richard W. Britt, MC, Chief of Professional Services, Convalescent Facility, England General Hospital

The Professional services of the RCF is set up in accordance with Circular Letter 108 to maintain medical supervision of the program at all times. The Medical Advisor's activities are coordinated with the rest of the Facility as shown on the organization chart.

To more fully understand the functions of these medical advisors, it is necessary to review certain physical and administrative details.

This section of reconditioning devoted to groups I and II is entirely separated from the main hospital, and the direct supervision of the patient by his ward officer is no longer possible. Eighty-four percent of our patients are formal transfers for reconditioning from other hospitals in this section. This necessitates examination, evaluation of physical condition, assignment, supervision and reclassification of all the patients by the Medical Advisors.

All admissions pass through the office of the registrar at England General Hospital. Those from England General Hospital are handled as any interward transfer. The patient and his clinical record are received in the office of the Medical Advisor where the charts are reviewed with attention directed especially at the final summary for recommendations that will be helpful in managing that individual case. We should be able to assume that a complete work-up has been performed and that no further diagnostic procedures or consultations are necessary. Unfortunately this is not always true and x-rays for determination of progress, blood counts, urinalysis and other procedures are often indicated.

A rule of the thumb that we use is to re-x-ray any fracture case who has not been x-rayed in the past 30 days, unless it has been reported that bony union has taken place. Grafts and other operative procedures on the bones are re-x-rayed unless one has been reported in the last 10 days.

The salient points of the history are reviewed and the examination of the patient is primarily directed at the injured part or the operative region. Joint range of motion, muscle atrophy, cicatricial deformity, condition of wound repair and any other outstanding features are noted at this time. The patient is questioned as to the amount and type of reconditioning previously given and how long he has been ambulatory. We ask him what he can do and how much he desires to do. The transfer diagnosis and this admission note is made in duplicate on a 55F form. The original remains with the clinical record as convalescent record of progress notes and the duplicate forms the beginning of our evaluation record.

A dental survey is made on admission and the required work is reported to the office of the Medical Advisor. Appointments for the dental clinic are then made at a time when it will not interfere with the remedial exercises.

From this information his initial assignment to the program is determined.

Our breakdown of patients into companies, platoons and squads according to their disabilities is one that has evolved over a period of time. We do not believe that it is the best nor that it can be adopted by every other convalescent center. It does meet our needs and will accommodate a large increase. It was originally devised to have squads with comparable disabilities together so that they could be more easily controlled in outdoor activities and prevent stragglers from falling behind and being lost in the crowd on the boardwalk. It also groups the patients for their remedial exercises when they march into a gymnasium by squads or platoons. The assignment is made, bearing in mind the exercises that will be given to that patient as one of various squads.

The gymnasia for remedial exercise is directly under the supervision of the Medical Advisor. The assignment of a patient to a certain squad, platoon, and company automatically prescribes the type and the amount of exercise therapy he is to receive. This is followed up in the gymnasium by the personal attention of one of the medical advisors.

It should be stressed that the remedial exercises are directed primarily at the affected part and with the exception of certain warming up calisthenics there is no attempt made at generalized physical toughening.

The noncoms in charge of the remedial exercise are well acquainted with the fact that they are leaders and assistants. They are urged to use as little discipline as possible and to be patient and tolerant. Disciplinary problems and refusal to exercise are referred to the Medical Advisor for necessary action.

In this way the confidence of the patient is gained and much better cooperation is obtained.

We are at the present time inaugurating a system of records which is to be maintained by the patient himself in the gymnasium. Weight, measurements, ranges of motion or any other data is recorded so as to show progress whereby the individual can prove to his own satisfaction that he is benefitting by his efforts.

Reclassification is accomplished by group appointments with the medical advisors. These are scheduled on the daily program and each patient is seen at least once weekly. Those who are on special details or for some other reason miss this check are issued appointment slips for a later time.

The admission note is reviewed and progress is noted and compared with his condition on admission. Again the need for x-ray or further consultations is considered and, if necessary, requested in the usual manner on the proper form. Usually an advancement is made into the next higher company and this fact and other pertinent data is entered on the convalescent record as a progress note.

The changes in classification are noted on a form and on Thursday are submitted to the office of the administrative assistant.

Advancements are routinely made once weekly on Friday, which has been found to be the most satisfactory method both professionally and administratively.

Sick call is held every day at 0800. Each man is seen by the OD, discouraged if it is for the same complaint he had on admission, placed on the sick book and sent to the Dispensary. Acute cases requiring bed rest are transferred to the hospital since no one is placed on a quarters status while in the facility. They may be given indoor employment however, if it is felt they should not actively engage in the outdoor program.

Our desire is to be able to advance each patient to A company or the advanced part of group I. This is not always possible of course, and our results now show that only 32% actually reach this stage. A certain few never advance beyond their original assignment due to some more or less permanent disability. The criterion that we use to determine their fitness for duty is whether or not they have reached the maximum benefits that can be expected from a reasonable length of time.

The following statistics are now available for the three-month period of January, February and March. During that time we have had a total of 1,119 dispositions, 1,142 returned to duty, 123 dropped from the register, 30 returned to other hospitals, 211 were re-admitted to England General Hospital, 93 of these were returned to us within a very few days probably because of some condition in the upper respiratory diseases. One hundred and eighteen remained in England General Hospital for further surgery or other disposition.

Certain explanation of these figures is necessary.

We don't mean to convey that all those who have been returned to full duty have stayed on that status, for our follow up reports indicate that a certain few have been reclassified as limited service. This is because they were not physically able to perform the work to which they were assigned.

Nor do we mean to imply that all that have been returned to a limited form of duty have proven useful soldiers.

We do definitely state however, that every man that has been returned to duty was, in our opinion, able to perform a useful day's work for the Army. Whether he was assigned with his disability in mind and given a fair trial or not, we cannot even guess. There are others who, though able to perform many useful and necessary duties in the Army, will not try. This brings up the problem of indoctrination of the soldier which will be covered by Capt. Dittrick as a function of Morale Services. The burden of responsibility however, rests on each and every commanding officer to see that these soldiers are given the proper assignments and impressed with the responsibility they hold. This is not a medical problem but one of good leadership and of command.

The ways of reconditioning in its early phases have been beset with many obstacles. One of the greatest problems we have had to face is the type of individual we have had to recondition. From my experience in the Army I am convinced that the patient sent to the convalescent center is not a cross-section of the Army or the average hospital patient. There are many problem cases who have taxed the resourcefullness of the ward surgeon and have literally been dumped on us for further convalescence and disposition. I am not being sarcastic in saying this because, as a ward surgeon, I have wished for that opportunity myself. Many times it is the proper thing to do since we have seen the relief of hospitalization work miraculous results and changes in attitude.

There are types of cases who should not be sent to a convalescent center and from our experience I would like to briefly enumerate these.

1. Acute arthritics become aggravated unless all inflammatory process has long been quiescent. The suggestion is offered that they be returned to duty after an adequate group III program or the beginners group II activities.

2. The long-standing traumatic arthritic is often aggravated by the activities of the advanced groups and might well be returned to a limited form of duty after an adequate III program.

3. Congenital deformities cannot be expected to improve in a 4 to 6 week program. We confess that we have had very little or no success in reconditioning those who are admitted to the hospital for pes planus.

4. Cases of chronic osteomyetitis with draining sinuses have no place in the group I and II program.

5. Nearly all ununited fractures must be transferred to the orthopedic service.

6. Peptic ulcers, unless symptom free and on a regular diet, rarely advance.

We can definitely report good results in the following cases:

1. Post-operative abdominal surgery.

2. Post-infectious asthenia following pneumonia, malaria, meningitis and other debilitating diseases.

3. Orthopedic cases who have developed atrophy and loss of function following the application of a cast.

4. Quadricep atrophy following successful operative procedures on the knee.

5. Fibrous ankylosis of a joint.

The results of our observations are in no way conclusive. Opinions formed in the early stages have been changed radically.

We do know however that this is a good program, a successful program and it is a great step in a mission for the Medical Department.

RCF TRAYMORE

1 Jan to 31 March 1944

TOTAL DISPOSITIONS		1419
TO DUTY		1142 (1)
FULL DUTY	661 (58%)	
LIMITED DUTY	481 (42%)	
RETIREMENT		17
DROPPED FROM REGISTRAR		13
ENGLAND GENERAL HOSPITAL		211
TO ENG GEN HOSP & RE-ADM TO TRAYMORE	93 (44%)	
TO ENGLAND GENERAL HOSPITAL	118 (56%)	
MENTAL HYGIENE UNIT		6
OTHER HOSPITALS		30
		1419

(1) OF THIS FIGURE 361 E. M. ADVANCED TO CO. "A".

RICHARD W. BRITT
Major, M.C.
Chief of Professional Services
Reconditioning Facility

COL. DURYEA: In the administration of any activity you make your plans and work it. 2nd Lt. Stanley C. Gillette will discuss plans and training of the Reconditioning Program.

PLANS AND TRAINING OF A RECONDITIONING PROGRAM

By
2nd Lt. Stanley C. Gillette, MAC,
Plans and Training Officer, Convalescent
Facility, England General Hospital

Like all training programs we too have a definite objective. However the problems that confront the Plans and Training Officer of a Convalescent Facility are quite unique and different.

Perhaps the best way to discuss this work is to present some of the problems and then tell you how they were overcome.

I would like to say here that these solutions are the result of eight months of trial and error, eight months of changing again and again until we finally found what we think are the right answers for our particular installation.

FIRST is the matter of control. We knew that to accomplish our mission we must segregate the Class I and II patients, not only according to their class, but according to their particular disability. These men had to be separated into distinct groups so that every physical activity scheduled for them would be aimed at exercising and improving their individual disability.

Another factor that presented itself was that, after a man had been in Class II for several weeks, his endurance and capacity for physical training was naturally much greater than the patient just out of the hospital. And so, in order to make his convalescence more gradual and yet more assured, we created a "II Beginner" and a "II Advanced" group.

Again, for the purposes of control, and also to detach ourselves from hospital routine and nomenclature as much as possible, we called each subgroup a Company, and each man in that Company a Trainee.

This has proved effective in every way.

SECOND was how to get each Trainee to cooperate and take an active interest in this program. Frankly, this was one of our biggest problems, but orientation talks by members of our staff, given shortly after a Trainee's arrival, have succeeded in getting him started off on the right foot.

We let him know quite bluntly that we are not interested in driving him, nor are we interested in entertaining him. We have but one interest, and that is his reconditioning. We discuss our training program and show him just how each activity will have a contributing share toward his recovery. We stress the importance of his need to help himself by working conscientiously at whatever he is asked to do. It is based on the proven proposition that, if you tell a man what you want and why you want it, you will get a better performance. In our case it is definitely working to advantage.

Our THIRD problem, in conjunction with any instructional program we hoped to initiate, was the question of progressive training. Courses had to be planned so that each period of instruction was as near complete within itself as possible. By so doing, no matter when a trainee enters the Facility, he can start classes immediately and without any handicap.

One advantage of a Convalescent Facility is that hospital time is no longer wasted time. To assure this we have prepared a certificate for training completed in compliance with War Department Circulars. One copy of this certificate is for the enlisted man's 201 File and one copy is kept for our records.

The FOURTH point I want to bring out is the necessity for close cooperation between the Plans and Training Officer and the Medical Advisor as regards the physical training program. Moving Trainees ahead too rapidly or too slowly will defeat the purpose of your entire program. Any deficiencies in reclassification must be called to the attention of the Medical Advisor and corrected immediately. All Company Officers and Non-commissioned Officers are instructed to observe each man's ability to participate in all phases of his groups activities and report any discrepancies at once.

POINT NO. 5, and the one I have heard discussed most often, is how to handle men back from overseas. Returnees, once our biggest problem, are now one of our greatest assets. Let me refer once again to our introductory orientation talks. It is here, right at the start, that we acknowledge their overseas service. We explain carefully the necessity for continued refresher training throughout their Army career; but most of all we impress upon them the value of their lessons learned overseas in all theaters -- under all conditions. We admit that we can all learn and profit by these very same experiences and ask that they feel free to get up during class and make any comments they see fit. To follow up on this our instructors conduct their classes on a fairly informal basis and turn part of the period over to these men.

By recognizing this and appreciating what they have gone through, we have won their confidence and cooperation.

And now, gentlemen, I would like to discuss the question of officer patients, or as we call them officer trainees, and the part they play in

your training program. During a recent Training Conference I heard a great deal of discussion about the problem they present. Here again, after months of trial and error, we have finally organized their training to the complete satisfaction of both the officer trainees and the Director of the Convalescent Facility. Briefly, this is how it works:

The senior ranking officer is designated as officer-in-charge, and he in turn selects his staff and personally interviews every new officer entering the Facility. Those officers qualified and expressing the desire, are assigned as company commanders in charge of the enlisted trainees. All others participate in a separate officers' program which they plan, supervise, and conduct themselves. Their proposed schedules are submitted for the approval of the Plans and Training Officer of the Facility and are coordinated with the training program for the enlisted men. Officer trainees are used throughout as instructors and staff officers -- selecting subjects that are of particular interest to them and discussing personal experiences gained in all theaters of the war. In addition to this, officer trainees are in charge of retreat, inspections, and other military ceremonies.

I would like to repeat that this is working to the complete satisfaction of all concerned.

A word about facilities, or I might say the lack of facilities. As you see our different activities, you will note the "home-made" aspect of our equipment. What we couldn't get on requisition, we made; what we didn't have, we built. Use skilled officer and non-commissioned officer trainees on work projects whenever possible. They enjoy doing it; they get the necessary remedial exercise, and in addition furnish you with much needed training aids.

In conclusion let me mention briefly our method of scheduling the various activities. In addition to weekly schedules for each company, we distribute daily a consolidation of each company's program for that day. These serve two purposes -- one of convenience and, in addition, enable us to make any necessary last minute changes.

All conferences are listed to include any visual aids available. By doing this we assure ourselves of the maximum use of training aids and make for more interesting and effective instruction. Notices are sent to all instructors one week in advance on a mimeographed form, listing all pertinent information.

I have tried to touch upon many of the problems that will confront you as Plans and Training Officers, or even Directors, of Convalescent Facilities. Time has been set aside later in the conference for a more personal discussion of individual problems at which time I will try to answer in detail any questions you may have.

COL. DUNLAP: One of the biggest problems we have in the Army is that of mental diseases of psychoneurosis. We have at England General Hospital, as you have been informed, mental hygiene units established more or less as experimental units. We hope this to be the solution of this problem. Major Freedman, who is in charge of the Mental Hygiene Unit, will discuss this part of the program.

MENTAL HYGIENE UNIT AS A PART OF A RECONDITIONING PROGRAM

By

Maj. Harry L. Freedman, MC, In Charge of Mental Hygiene Unit, Convalescent Facility, England General Hospital

The Mental Hygiene Unit in this installation has been in operation for a little more than five months. It has functioned here in an experimental mission toward developing a psychiatric treatment program for the NP casualty to salvage for the Army and return to duty as many of these men as possible.

The presence of neuropsychiatric breakdowns in the Army has become a serious problem to all Branches of the Service actively engaged in carrying out their tasks. The soldier who has suffered a so-called nervous breakdown in his normal functioning becomes thus a responsibility of the Army's Medical Corps in terms of treatment, as well as disposition. The increasing rate of discharge due to emotional problems becomes particularly serious when viewed from the point of view of our manpower shortage, not to mention the personal effect upon each individual concerned. It is apparent that as long as over one-third of all discharges are for psychiatric reasons, that the Armed Forces are at the same time being depleted of this number of effective man power units.

There are still problems to be met and techniques to be further developed. The methodology of this Mental Hygiene Unit approach, though unique and limitless in possibilities, will be elaborated upon at later discussions this afternoon and tomorrow afternoon.

At present, I will give you a bird's eye view of what you will see and hear about later, as time will permit.

The Mental Hygiene Unit is composed of a team of highly trained professional clinical workers, all having considerable experience in dealing with psychiatric problems in the Army before undertaking this new mission. The interlocking responsibilities of this team are divided among the psychiatrist as Director of the Unit, eight psychiatric social workers (SSN #263), three of which participate in the group therapy program, and two psychologists. All are enlisted men. The psychiatric social worker (SSN #263) may be least familiar to you. He is an enlisted man who has been trained in recognized graduate clinical work as a civilian, to counsel individuals with severe emotional problems under the direction of a psychiatrist.

In this Unit, he carries out a large part of the counselling and planning with each soldier. Under the psychiatrist's supervision. As has been indicated elsewhere, "counselling" has been equated from a broad point of view with psychotherapy. We cannot, at this time, be concerned with a discussion of theoretical aspects and types of psychotherapy, individual and group, except to say that our approach is pragmatic, but always with a distinct military focus, and has proved successful.

All soldier-patients referred to this part of the Convalescent Facility are placed in a special Line Company while under treatment. For the first time in months, many of these soldiers are out of the hospital and again participating in a program of regular Army life. All of these patients have been given thorough medical work-ups and the existence of functional disorders has generally been well established diagnostically. Thus, the first problem facing these men and the Army, is their inability to perform a useful Army job. The primary responsibility, method of treatment and disposition is therefore not through a mental hygiene and psychiatric orientation to their problems and becomes the basis for the entire program at hand.

The initial processing of each patient referred proceeds along several well defined steps.

The soldier is seen by the psychiatrist for screening, initial orientation and initiation of necessary medical clearances. The soldier is then placed in the line company and informed by the company commander of his schedule of activities and company responsibilities. The company commander also discusses with him his placement in one of the platoons: the advanced or soon to return to duty group; the intermediate or trial of duty group (usually for soldiers having some physical or functional limitation); or the third platoon, consisting of those men who appear able to function only under conditions of minimal exertion and responsibility.

Within 24 hours of his arrival, the soldier is then seen by the psychiatric social worker who begins both study and counselling as indicated by the individual soldier's problem. The F-20 card, service record, 201 file are all processed for pertinent information. A history of the soldier's problem ,both in civilian and Army life, is obtained in detail and all significant facts are recorded. The soldier's preliminary status is then discussed with the psychiatrist, as to existing potentialities for return to duty, nature of treatment, or recommendation of discharge if not amenable to treatment. Since it is often not possible to predict this early whether or not the soldier can respond to treatment, he may be considered for inclusion in the program on a so-called "trial of duty status". In many cases a complete psychological work-up (intelligence and personality testing) is requested of the psychologist, either immediately, or as continued treatment brings out new factors that may require special analysis as to future handling of the same.

Unless decided by the Director earlier, another step in the process, which usually takes place at and is a part of the psychiatric social worker's first interview, is assignment to the group therapy program. This is made wtihin the Unit through referral from the psychiatric social worker to the group therapist with whom the soldier will discuss assignment, subject to the Director's approval. The purpose of this program (which you will see later) is to give the soldier an opportunity to discuss or participate in activities in which he is interested. The groups consist of a fairly homogeneous group of men who have all had Army jobs of a similar or related nature, so that they are at once brought together on the basis of Army material. It tends of itself to divert them from the usual preoccupation with their complaints, and stimulates an interest in Army related activities. This is an important step in the initial mobilization and motivation for return to military duty.

The dynamics of this group therapy program require the skilled leadership of the group therapist under the direction of the psychiatrist.

It should be kept in mind that there is constant interchange of information and planning for each individual soldier among the psychiatrist, psychiatric social workers, psychologists, group therapist, and the company commander.

Thus, with this method, it has been possible to concentrate the greatest amount of effective treatment time, both quantitatively and qualitatively, used with each soldier so as to bring about as much economy in the use of this service as possible.

AFTERNOON ACTIVITIES

PRESIDING: Col. R. E. Scott, MC, Director, Convalescent Facility, England General Hospital.

COL. SCOTT: Members of the conference we will continue at this point according to schedule. The schedule is to review the day's activities with all of us taking part. Possibly we are all a little tired, but the day isn't over yet. I have been asked a few questions. I will try to answer the simple questions that can be answered quickly. Any questions of a general nature to be taken up at the open forum tomorrow afternoon, please submit them if you can when you come in this evening. I will try to get them to the officers who can best answer them.

I have been asked where we obtained the physical education clothes and the uniforms that the physical education trainers were wearing. Those suits were donated. I have been asked where we obtained the gymnasium suits. Those were requisitioned from Bailington Depot and obtained from there. I have been asked whether these I and II clases are allowed to select their games that they play on the beach. We do try to get the men to select the games that they like if it fits into a form of training that will benefit their physical condition. We have found that men playing volley ball decide that they would like to pitch horse shoes. A few minutes after pitching horse shoes they would like to do something else. So these things must be supervised. Volley ball is best indicated where suitable, and he must play volley ball. I was asked how the patients come to us and how they are returned from us. All patients are admitted to the England General Hospital. They are sent to the Convalescent Facility Classes I and II, the same as interward transfers, which means that the history comes to the Facility and the Medical Advisor has it at all times. When enlisted personnel, in the opinion of the Medical Advisor are ready to go to duty, that fact is sent to the registrar. All administrations are handled by the Sick and Wounded Officer, the Registrar of the Hospital.

This evening according to schedule we are to be addressed by the Chief of the Professional Services, Surgeon General Hillman. Following that we have a motion picture presented by Captain Sidney Licht of the Lovell General Hospital, "Relations between Physiotherapy and Occupational Therapy." I have not seen the picture but I understand it is an interesting one. Following this we have a picture presented and produced by Major Arthur A. Esslinger now of the Reconditioning Division, Office of The Surgeon General, formerly of Lexington, Virginia. I understand that it is extremely interesting. We are very glad to have it. After the general proceedings this afternoon we will witness formal retreat. Retreat will be on the beach. The groups as usual will march out onto the first and second tiers overlooking the boardwalk and observe it from there. The flag will be lowered and the color guard will be on the first and second tier. Now we will have Major Britt discuss the purpose of the remedial exercises, remedial gymnasia and the games you witnessed today. Possibly he can give you some of the statistics. Major Britt:

DISCUSSION OF PURPOSE OF REMEDIAL EXERCISES, ETC

BY

Maj. Richard W. Britt, MC, Chief of Professional Services, Convalescent Facility, England General Hospital

MAJOR BRITT: gentlemen; statistics have been asked at every corner we have turned today. Unfortunately we don't have complete statistics to give you. We have worked them out for a short period and I would like to just run over these that we have worked out. The average stay for all cases is 33 days. That varies from month to month by 2 to 5 days. The average stay by diagnosis has been hurriedly worked out as follows: Those coming in following care of hernia, 29 days. (I might say, however, that this period is just until their 8 weeks post-operative has been completed. We try not to get them back to duty sooner than 8 weeks, but when they go back it is to dull duty.) Post-operative appendectomy 33 days. That shouldn't be as long, and this has been called to our attention. Most of the post-operative appendectomies should not be here over 3 weeks. Pilonidal cysts, 23 days. Now the question comes up, "Why are they sent here?" Those that are operated upon and closed primarily, should not be sent here. They are averaging about 27 to 30 days hospitalization post-operative. However, those that we do have, have been in the hospital anywhere from 2 to 5 months. Now that is rather astounding. We worked up a series of 30 cases and the average length of stay was 112 days. They were the complicated ones, I might say. Excised, packed and healed by granulation. In pneumonia cases the average stay is 34 days. This is primary atypical pneumonia with complications such as empyema or other complications. The arthritic cases average 27 days. Malaria, 35 days. The reason for that length of time, is that many cases have been rehospitalized for recurrencies. Fractures of all regions average from 41 to 47 days. Now the difference between 33 days, the average for all patients, and the higher figures, is that many come out within a week or ten days; they do not need prolonged convalescence and reconditioning.

This morning I covered generally, the functions of the Professional Services. Following that you witnessed the general conditioning calisthenics and games at Convention Hall. Lt. MacNamara stressed the fact that their effort was directed at general body reconditioning and toughening of the injured parts. The lower extremity cases received calisthenics for the trunk and the arms. The upper extremity cases received calisthenics for hips and legs, and we tried to emphasize the exercise that would give them most benefit. "A" Company was very small; rightly so, for those men that you saw will be out to duty by the end of this week. Many of the men in B, C, & E Companies looked fit for duty. Compared to the average patient sent from the hospital to duty, they are, however, capable of A company's activities and the 15 mile hike which they will receive Monday or Wednesday of next week and then will be returned to duty since their job is much easier than our program.

This afternoon you saw the remedial exercises given in our gymnasia here in the Traymore. Here the emphasis is placed on the strengthening of the injured part. Our objective is to re-educate these muscles. The remedial exercises must be balanced and closely supervised with as much individual attention as is possible. The physical education trainers are constantly circulating from one to another, encouraging and assisting; and are ever alert for indications of injury or damage to the healing process. They immediately report any questionable case or error in assignment to the Medical Advisor. Patient Officers of the Medical Corps are assigned extra duties in the remedial gymnasia to assist our staff in the supervision of these activities.

The physical education trainers, who are assigned to field work, perform the same functions. Now, these activities that you witnessed today were not standardized. Men who participated put forth every single effort on their part. They looked better today than they do the average run of days. They were trying as well as everyone else. The program did not show upper extremity disabilities. However, their program is conducted in the same manner as are lower extremity disabilities.

The work of medical supervision is not easy. To determine a patient's tolerance and to assign him to the proper group is in many cases difficult.

It is necessary to see the patient in the gymnasium, on hikes and marches, in calisthenics and at play whether this be at volley ball in Convention Hall or at a dance in the Germantown Y. M. C. A. All of his activities must be observed and reported to truly evaluate the trainee's status. I don't mean to give the impression that we have a Gestapo at work, but rather that when these men are seen on their weekly reclassification examination, we want the platoon sergeant, the physical education trainers assigned to that company and the Company Commander present to give his impression of a man's capabilities. This information coordinated with the known physical condition gives a fairly accurate picture of his status.

Upon completion of the program at this Facility, we consider what he has accomplished and what his residual disability is. We consider his attitude, his cooperation and his desire to get well. From these facts we recommend the type of work to which he should be assigned and the facts to be considered when future assignments are made.

We are re-emphasizing, to the point of becoming monotonous, that our duties are two fold: first, to strengthen, re-educate and return to normal function an injured part, and second, to generally strengthen and recondition the rest of the body that has suffered from the inactivity of hospitalization.

COLONEL SCOTT: This morning, Major Freedman, of the Mental Hygiene Unit, gave you an over-all picture of his particular activities. At this time he will discuss at greater length the actual mechanics, in words of particular importance, of the reconditioning facility. MAJOR FREEDMAN:

THE MENTAL HYGIENE UNIT APPROACH TO RECONDITIONING THE NEUROPSYCHIATRIC CASUALTY

By
Major Harry L. Freedman, MC
Director, Mental Hygiene Unit
England General Hospital

As an introduction to the program developed for the reconditioning of soldiers with neuropsychiatric conditions at the Convalescent Facility of England General Hospital by the staff of the Mental Hygiene Unit, it is most appropriate to repeat the thoughts of Assistant Chief of Staff G-3, Major General Ray E. Porter. In sounding the keynote of the recent conference at Clinton, Iowa, in March, he said:

"I do not hesitate to say that mental reconditioning is the most important of the three activities you must undertake. In many cases, it will be the most difficult Success will only be achieved through personalized effort. Those conducting this training must have their hearts and souls in their work. They must deal with each trainee as an individual. They must gain the confidence and respect of each individual; and they must administer to the peculiar needs of each individual. I am sure problems of mental reconditioning cannot be accomplished through any mass methods."

After two years of functioning in the Eastern Signal Corps Replacement and Unit Training Center at Fort Monmouth, New Jersey, where the Mental Hygiene Unit worked with soldiers presenting problems of adjustment to military training prior to combat experience, the entire Unit was transferred to the England General Hospital to work out a plan and program of reconditioning for the neuropsychiatric casualty. During our five months at the England General Hospital, we have adapted the professional skills and techniques of our staff to the new problem of reconditioning psychoneurotics.

The basis on which the Unit has been functioning is clearly set forth in WD Cir. 168, 21 September 1943; WD Cir. 293, 11 November 1943, para. 2a,b; para. 4a 1; WD Cir. 100, 9 March 1944, II, 2c, III, 1 and 4. Herein is again emphasized the need for evaluation and disposition of cases with particular regard for the individual soldier's mental or physical capacity.

The Therapeutic Setting

You have, in your tour of the company and MHU, become familiar with its physical set-up and organization; I would like, however, to emphasize certain dynamic characteristics of this type of line company.

While the soldier is now out of the hospital setting, he is not yet back in the Army with a definite assignment. However, he is in the Army much in the same manner as any man assigned to a reception center, casual company or pool, although here in a therapeutically controlled military environment. Psychologically, the atmosphere is Army-like, focussed back to duty and toward the strengthening of his military orientation. Practically this company is a

part of the Mental Hygiene Unit, and where occupational, recreational and physical aids are used in the over-all therapeutic-reorientation program. Since most of these soldiers may have experienced the ill effects of prolonged hospitalization, this change in itself becomes a potent therapeutic factor. In this setting, he can rediscover the strengths he has which may become the foundation for eventual return to duty. It represents the first step forward from a period of physical or neurotic invalidism. Their abilities and performance are carefully observed and the company commander attempts to keep each on the highest level of performance in the company of which he is capable. Some patients are encouraged to take over a squad or a platoon among the varied responsibilities in which they may try out their growing confidence.

The basic philosophy upon which this company has been formed and functions is the principle that a soldier's first step from hospital to duty should be an intermediate trial of duty period away from the hospital wards and out of the bathrobe. He is observed in a line outfit that bridges the gap to duty assignment as the effect of the entire program is constantly tested under Army requirement.

Coordination of Line Company with Mental Hygiene Unit

The closest possible coordination of the work of the Mental Hygiene Unit in each individual case with the company commander is required. This is accomplished through frequent conferences between company commander and the various members of the Unit as needed in each case. All aspects of the company's program are discussed in detail to meet the special problems of this group of soldiers. Such questions as disciplinary action are often taken up from the point of view of the individual concerned so that the company commander can be assured of using such measures as constructively as possible. The principle here is always recognition of the need for a military atmosphere; leniency is not a policy because it would defeat the use of the company's function as a military unit.

The company commander particularly is aware of the need to bring out any special problems of the individual soldier to the Unit's attention so that no time will be lost in taking proper treatment measures. By the same token, the company commander is always informed of the need for closer supervision or observation of any individual soldier. Much is learned in such a controlled environment about the soldier's ability to get along in a group, the degree to which he can perform his duties responsibly, the difficulties created by his problems. All of this becomes a realistic measure in the progression of treatment upon which sound recommendations for future military duty can be made. From the standpoint of psychiatric understanding, such a "functional company" in this pattern of treatment has fully justified itself over an experimental period of actual practice.

The Role of the Psychiatrist

The clinical and administrative functions of the Director of the Mental Hygiene Unit are threefold:

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The Role of the Psychiatrist

The Clinical and administrative functions of the Director of the Mental Hygiene Unit are threefold:

A. He sees each new soldier immediately upon his arrival for screening, initial orientation, and initiating necessary medical clearances. It is important in this connection to rule out or define the nature of all complaints which have an organic basis prior to planning the treatment program.

B. The psychiatrist has regular contact with each soldier and is kept informed on all factors affecting his progress in the Unit and the company.

C. He supervises each member of the Unit's team in the application of his particular part of the total job and has full responsibility for preparation of all reports, final dispositions, and recommendations made by the Mental Hygiene Unit. The Director also works according to the policies and procedures defined by the S.O.P. of the Convalescent Facility, with all sections in the hospital proper in order to maintain efficient and smooth functioning of the Unit.

General Orientation of the Soldier

Following the interview with the psychiatrist, the soldier (or soldiers) is seen by the Sergeant Major (a military psychiatric social worker (SSN #263). In this meeting, the various purposes of the program are further elaborated. The continuity of the soldier's first contacts with the Unit all serve a very specific purpose in helping him relate to the meaning of his new environment. The interview with the psychiatrist, the orientation session and tentative planning of company placement with his company commander all have been found to effect most soldiers positively from the beginning. It relieves them of the anxieties created by uncertainties during hospitalization.

The Role of the Military Psychiatric Social Worker (SSN #263)

The next contact which the soldier has is with the military psychiatric social worker (SSN #263). He utilizes his skill under the direct supervision of the psychiatrist and in collaboration with the clinical psychologist and military group therapist in the treatment of the total personality as it relates to the soldier's problems and potentialities for Army functioning.

The objectives of the military psychiatric social worker are to evaluate the soldier's present behavior, attitudes, and symptoms or complaints as they have been and are being manifested toward the Army in order to determine what is blocking his effective functioning and what may be expected of him. The soldier's civilian social adjustment, as well as his previous military accomplishments, or lack of them, are studied with him. In his initial contact, the military psychiatric social worker can, in most cases, develop some perspectives as to the possible potentialities of the soldier-patient. All of the Unit's skills are focused upon early disposition of non-treatable cases; the Unit's therapeutic program is devoted primarily to those who are most likely to return to duty.

The military psychiatric social worker's part in the treatment takes the form of "counselling." Simply defined, counselling is a series of direct contacts or interviews with the soldier-patient which aims to provide him with assistance in changing his attitudes and behavior in relation to Army realities. It is an opportunity for him to talk out, talk through, become aware of, and integrate his personal preoccupations and fears, reasonable and unreasonable, so that he may achieve a measure of self-confidence. It may give him the eventual "spark" to complete his preparation for further duty. For the overseas combat casualty, it may help him to regain his self-initiative and work through some of the repetitive fears which have been precipitated as a result of actual combat.

In the counselling process, the psychiatric social worker has and uses his understanding of the unique psychological conflicts and experiences under military service which have led to breakdown of the individual soldier. Through his awareness of the patient's attitudes, feelings, and resentments, as well as assets, and through his knowledge of the Army and its regulations, as well as his ability in administering the particular service of the Unit, help is offered to the psychoneurotic soldier. He generally provides about two and one-half hours per week of individual counselling for each case.

The psychiatric social worker cooperates with the other members of the clinical team. He refers patients to the various activities of the group therapy program, and in return, receives continuous reports from the group therapist as to the progress of each man. He utilizes this knowledge in the counselling process. A knowledge of the diagnostic findings of the clinical psychologist, as to the soldier's personality structure, his attitudes, capacities, and skills, are also brought to bear. Reclassification may be indicated in some cases; a simple change in assignment may go a long way in reorienting the attitudes of a soldier in a positive direction. For example, the mild-mannered, quiet individual, who broke down while serving in the Military Police, turned out to have a complete fear of carrying authority, but had a good knowledge and enthusiasm in auto mechanics. He was recommended for such assignment.

Throughout his functioning in the Unit, whether in initial diagnosis, during continuous counselling, or in formulation of a recommendation for assignment, the psychiatric social worker is under the supervision of the military psychiatrist.

The Military Group Therapy Program

Through the military group therapy program, attempts are made to meet individual needs through the group program. Small groups (maximum is 10 soldiers) are organized on the basis of the individual soldier's interest, thereby giving a homogenity of interests within the group; this number is held small so that individual attention can be constantly rendered. Overseas men are generally separated from nonoverseas men. At this time, such groups as auto mechanics, electricity, Army administration, and clerical work, exist and it is around such interests that the soldier is able to work

through his problems. These groups are not classes, but rather are small informal group sessions in which the soldier is encouraged to say what he pleases and to express freely his feelings on all matters that come to his mind. These feelings are expressed through actions and activities, (such as in demonstrations of the transmission, carburetor, etc.). A rather important characteristic of this program is that the content discussed in these informal sessions is geared to real Army assignments. It emphasizes the soldier's ego strengths, and attempts to get him involved in some positive activity away from his personal problems. It does not, however, serve as an escapist or covering-up process. Each soldier is given ample opportunity to express himself, whether negatively or positively, and through the group process, brought to a point of readiness for return to duty. The group process involves activity catharsis, self-expression through activity, development of interest, and reorientation toward return to duty. The progress of one individual encourages another to more positive effort, thus the inter-personal interaction within the group is of primary therapeutic value.

The military group therapists work closely with the individual case worker in assisting the psychiatrist to evaluate the soldier diagnostically and in his treatment. Group therapy complements individual therapy and one cannot exist without the other in this setting. There are periodic conferences with the psychiatrist and the psychiatric social worker where the progress of the soldier-patient is discussed and evaluated for further treatment and disposition. The group therapy program has diagnostic, as well as treatment values in that it screens out those soldiers who are unable to relate to the group. In such cases, the individual is returned to his psychiatric social worker where intensive counselling or psychiatric case work treatment is continued.

Each soldier attends, on the average, 3 sessions per week, 1½ hours per session for a total of 4½ hours of group therapy per week.

One of the more interesting features of the program, is the use of officer-patients and enlisted men together, in the same process. Officers, as well as enlisted men are utilized to lead special discussions about which they are skilled. This serves as part of the therapeutic process in helping them regain their confidence in themselves and a renewed sense of contact with Army life.

At present, there are 5 groups functioning with more contemplated. These groups are: 1. Auto Mechanics; 2. Electricity and Radio; 3. Army Administration and Clerical; 4. Non-Com Leadership; 5. Army Orientation.

The Clinical Psychologist

The psychologist, as an integral member of this clinical team, fits into the treatment of the soldier's total personality through the various services he gives to both the diagnostic and therapeutic aspects of the Unit's over-all responsibility. His area of function is at least twofold: first, the more traditional role of determining the soldier's intellectual capacities, special abilities, interests and skills thru the use of standard validated tests and clinical procedures. Second, the psychologist

performs clinical evaluations of personality patterns as a further aid in providing diagnostic criteria useful in cases of questionable clinical diagnosis. Recent progress in personality testing in evaluation by special psychological procedures, as the Rorschach, Thematic Apperception and Harrower-Erricksen techniques have been found helpful. More specifically, the psychologist adds his methods to the Unit's diagnostic and treatment and planning needs. Further adjustment has been the use of group test procedures where it is paramount that information be available very soon after the soldier's placement here. Since diagnostic factors obtained by the clinical psychologist often give clues to the treatment of a psychiatric disorder, his findings are often of assistance to the psychiatrist.

The evaluation of a soldier's intellectual functioning may itself be crucially important in discharge as in return to duty cases. In the former, the soldier's intelligence and special aptitudes are always a factor in determining the recommendations for return to duty . Because of the very appreciable number of overseas men whose -20 cards have been lost, or unduly delayed in transit, it has been found necessary to give many of them intelligence evaluation.

The psychologist generally gives two hours of clinical time for a fairly intensive testing and interview program. He usually administers three tests to a patient: one on intellectual functioning especially of Class IV intelligence, one on aptitude, and one or two in personality functioning, especially of the projective type, such as the Rorschach Ink Blot Test, etc. All psychological data are obtained in relation to specific questions and problems as they pertain to the individual case and thus used in a functional manner so as to make for maximum efficiency of the Unit's psychological service.

Return to Duty and Follow-Up

War Department Circular No. 100, 9 March 1944, charges the Unit commander with responsibilities to give the individual an assignment appropriate to his mental or physical capacity when a condition exists which requires special consideration in reassignment or reclassification. The Mental Hygiene Unit discharges the responsibility of the Medical Corps of transmitting the necessary data to facilitate this process by forwarding a 201B letter, through channels, in which the soldier's limitation and Army potentialities are clearly set forth. To insure that this information comes to the attention of the Unit commander, the soldier's Special Orders are further worded as to recommend reassignment, reclassification, or further training within the specifications of AR 615-26. This procedure not only makes available to the Unit commander the necessary professional appraisal, but also gives him a recommendation oriented to the Line Organization which he can find practical and useful. Since the soldier has participated in this process, he is aware of his capacities and limitations and knows where the Army stands in relation to them. Since the soldier who has a neuropsychiatric condition where anxiety is always a basic factor, the therapeutic value of this knowledge cannot be underestimated.

Follow-up reports are requested through channels on the men who have been returned to duty. These reports are periodic and are related to the soldier's assignment, efficiency rating, physical and mental condition. As of April 1, based on those follow-up reports received, 90% of the men returned to duty during January, February, and March 1944, after having been processed at the Mental Hygiene Unit are continuing to render useful military service.

SUMMARY

Inherent in the process described is the continuously changing attitudes and behavior of the soldier throughout his period of convalescing, in a line company therapeutically controlled by the Mental Hygiene Unit. There is adequate opportunity through the integrated approach with the Company, the military group therapy program, the individual interviews, and contacts for a very careful appraisal of the soldier's personality strengths and weaknesses, as well as his intellectual capabilities and limitations. The soldier has demonstrated the degree of responsibility he is capable of assuming through his participation in the program. The entire process has been related to the requirements the soldier will be expected to meet in a duty status. A specific assignment by Army specification serial number for which he is qualified, with retraining and reclassification may be recommended. In this, the soldier has participated and he is aware of the limitations which are involved in such decision as defined by Army directives, indicated above.

The Unit's team is a new principle in the application of professional skills in Army psychiatry. The principle of the Mental Hygiene Unit has here demonstrated a very vital and special usefulness for dealing with the problems of the neuropsychiatric casualty of military life. It has been shown that just as the Civil War gave impetus to the growth of neurology, and World War I to the roles of psychiatry and psychological testing, World War II is bringing about the recognition of usefulness of the Mental Hygiene Clinical Team as a most effective combination of psychiatric, psychological, psychiatric social work, and group therapy skills toward the pressing problem of neuropsychiatric casualties.

COL. SCOTT: I am going to introduce the Commanding Officer of the England General Hospital, Colonel James P. Cooney.

COL. COONEY: In order to get my name on the program, Col. Scott asked me to briefly review the evening program. At 1720, Retreat on facility beach. We have arranged with the Chamber of Commerce so that we will not have rain at that time. We will have mess at 1800. This evening Col. Walson will preside. At 1930, General Hillman will speak on Expanding Fields for Reconditioning. At 2000 a motion picture on the relationship between physiotherapy and occupation therapy will be shown. At 2020, a motion picture, Techniques of Reconditioning, will be shown. I hope you are enjoying your stay here, gentlemen; we are glad to have you.

COL. SCOTT: That is all. Get with your group leader and stay with him closely.

EVENING ACTIVITIES

PRESIDING: Col. C. M. Walson, Surgeon, Second Service Command

Col. WALSON: Ladies and gentleman, our speaker, our distinguished speaker this evening at his desk needs no introduction. I have known him for nearly 30 years. He may not always admit that, but time tells the story. In this reconditioning program our Surgeon General has shown his unusual ability in selecting this officer to head the Reconditioning Program. There are two reasons- first, this is a problem that is vital to the Medical Department and its reputation. It needed a good doctor. This officer has been known to the service for years in that capacity and has taken care of many of their families throughout the service. That is one splendid requisite. The other is an officer with a great deal of executive ability and who has had a great deal of experience in administration. He not only had this prior to his direct divorce from bedside treatment, but in long experience in the Surgeon General 's office. Therefore I think our Surgeon General showed unusual ability to select this officer because of his administrative ability and his knowledge of men which every doctor gets from private practice.

It is a great honor to introduce my friend, General Hillman

EXPANDING FIELDS FOR PATIENT RECONDITIONING

BY

Brig. Gen. C. C. Hillman, Chief of Professional Service Division, Office of the Surgeon General

GENERAL HILLMAN: Col. Walson, Col McDonald, fellow members of the conference - I regret very much indeed that time has not permitted me to write out a formal presentation of my talk tonight and I will ask your indulgence while I speak extemperaneously from a few notes. Possibly I will wander a bit from the subject unintentionally, and possibly intentionally take some liberties and get a little bit afield.

The title is recorded on the program as Expanding Fields for Reconditioning. I might reword that and suggest the title Expanding Fields and Facilities for Reconditioning. Up until very recently our ideas of a reconditioning service in a hospital has been the hospital unit itself with the classes IV and III of reconditioning and an advance reconditioning unit, classes II and I. And we have tried to set up for this advanced reconditioning section, facilities not exactly adjacent to the hospital proper, but preferably a little distance away to enable it to run more independently and with an air of the military rather than of the hospital. This has generally helped. There have been variations where there have been no facilities outside the hospital proper and hospital wards, if necessary, have been used for the classes II and I of the advanced reconditioning section. At other places we have had very fine facilities available and have established our classes II and I in accepted facilities which offered everything to advantage. Ordinarily each hospital has had its own

facilities and has been a self-contained unit. This facility is the one notable exception where patients have been accepted from hospitals afar for class I and II reconditioning. At the present time we are faced with a further extension of the situation that exists here. With the perspective push in western Europe we have every reason to think that within the coming months we shall have battle casualties in considerable numbers. The facts are that we will have, we have every reason to assume, casualties that will overtax our existing hospital facilities and with a view to economy and hospital construction, and with a view to taking advantage of the possibilites of putting out our convalescent patients in facilities that were not primarily intended for hospital purposes, it is now contemplated that we shall have available our present general hospital facilities largely for returning casualties from overseas. And in order to take care of these casualties we will have to put the patient who is not in need of fairly close medical supervision into these facilities of which I spoke, that were not originally intended for hospital purposes. Now according to WD Cir 140, a new type of hospital has been provided for generally throughout the service. This is a so-called regional station hospital. It was originally planned by the Air Service for certain of their installations and now has been adopted by the War Department for general use in the continetntal United States. It is contemplated that regional station hospitals shall act essentially as general hospitals for sick and wounded or injured occuring in the United States. It is not contemplated that they shall be used for special types of medicine and surgery. This will mean therefore that sick and injured from the United States will be largely hospitalized in regional hospitals eventually, and that the main general hospitals will be utilized largely for returning overseas casualties. Now what does this mean? It means that the general hospital, the main general hospital, as it now exists, will have largely classes IV and III patients. It means further that the patients we now have, classes I and II patients, will necessarily be handled in these additional facilities which we propose to have.

These additional facilities consist largely of barracks in our various training camps that are no longer needed for troops and training. Most of them will be near our present existing hospital facilities. In a very few instances they may be at camp sites that are notadjacent to any of our main general hospitals or large station hospitals. I have in mind one or two places that the Surgeon General's office is considering. Just for example, the WAC training camp at Daytona Beach, Florida, is a sample. It is an excellent camp with an excellent station hospital and will probably be utilized as one of these station hospitals. I have in mind another place near San Diego, Camp Lockett, California, which is on the beach and an excellent site. It will probalbly be so utilized. There are probably others that will be located apart from the main general or regional station hospitals. But most will be in the vicinity of such hospitals. This simply brings out the point that the reconditioning work will change materially. The work in our hospitals as it now exists, will tend to require more emphasis on classes IV and III with a transfer of reconditioning activities for classes II and I facilities yet to be set up. Another expanding field for reconditioning has to do with neuro-psychiatric cases.

As one of the speakers mentioned to-day, I believe it was Major Freedman, we know that the psychoneurotic patients can be sent out of the hospital when it is to their advantage. In other words, he should be subjected to a minimum of hospitalization. It is detrimental to that patient to be sent from one hospital to another and kept for long periods of time in pajamas and bathrobe, to have his psychoneurotic condition emphasized by hospitalization and a hospital atmosphere. It is felt by all, I think that it is very desirable to have this patient kept out of the hospital atmosphere and directed into a military atmosphere as rapidly or early as possible. We have in mind, therefore, that our advanced reconditioning section should have a platoon or company devoted to the open ward. Neuropsychiatric patients coming into the hospital should be given a brief period of study, maybe only an examination as he comes in, maybe a day or two or three to determine whether he can safely be put in the advanced reconditioning section; and it is our thought that just as soon as that patient can be put into the advanced reconditioning section, put in barracks in a uniform or possibly kept in uniform, rather than admitted to the ward and kept in pajamas and robe, the better it would be for him. That means a study of that individual must be continued after he gets into the advanced section. In other words, we are mixing in here a bit of treatment a little bit beyond the idea we have had heretofore, that which is proper for an advanced reconditioning section. We believe, however, that this is a step in the right direction. It will necessarily mean that the officer in charge and the chief of the neuropsychiatric section of the hospital will have to maintain a very close working relationship in order that any further psychiatric examinations that are necessary and physiotherapy can be carried on simultaneously with what might be considered reconditioning in the advanced reconditioning section. Now just a few words about additional facilities. The Surgeon General's Office has attempted the best it knows how to get priorities on gymnasium and occupational therapy equipment, to supply you with the items listed in the standard lists of medical supplies. I think most of that equipment has been coming through in greater volume. Let me suggest that you consider your hospital fund as a proper source for the purchase of equipment for your reconditioning program. You know of the additional facilities offered by the United States Armed Forces Institute, and I am sure that further discussion of that will follow. Also you know the publications of the Morale and Special Services. I am sure there will be further discussions of those facilities for education and morale work later on. Our big problem as I see it, concerns personnel. We hope again to get the approval of the War Department on Circular 73, and have it issued on our problems relative to personnel for the carrying out of our reconditioning program. I still have hopes. I think it is the intention of those that have to do with these matters, the heads of the Army Service Forces and those on the General Staff, that every possible facility will be provided to set up an adequate reconditioning program. I believe the War Department, from the Chief of Staff down, is sold on that idea, and I have little doubt that very shortly the kinks will be ironed out of the personnel matters having to do with our program. You must understand, of course, that you can't go out and gather in these people who don't exist. We do not have enough officers in the service trained in physical reconditioning. They are certainly not available in the service.

We do not have enough enlisted men trained in physical education to fill all our requirements at present for our reconditioning program. However, facilities are being set up for the training of physical education instructors, that is enlisted instructors and educational reconditioning officers. Also facilities have been set up for the training of additional occupational therapists. Although not closely connected, facilities have been set up and are operated for the training of neuropsychiatrists. A subsequent speaker will discuss these more at length. One thing I am especially gratified at seeing here, and at seeing at some of the other hospitals that I have had the privilege of visiting, is the use of officer patients for the good that it does for those officer patients. It is well to have them engaged in the recondition program actively and fully, and in assisting in carrying out the Reconditioning Program among the enlisted patients. They can be of further service. Down at McCall General Hospital at Louisville, Kentucky, a few days ago we were privileged to see officer patients being instructed in physical exercises that were adapted for use on hospital wards. Each of these officers had a ward assigned to him, also a ward leader from among the enlisted patients in that ward. The officer-patients and the ward-leader patients first engaged in a short period of instruction prior to assuming their duties, and following that, carried out the Class IV and III physical reconditioning on various wards. It was being done in a very fine manner. General Marshall is extremely anxious to have officers who suffered battle casualities and who have as a result, had to be reclassified for limited service, to be given that privilege without detriment to themselves while they are patients in the hospital. He has, furthermore, expressed the wish (and that wish is being carried out) that officer-patients who have faced longer periods of hospitalization, during which time they will need very little, if any medical attention, be given the privilege of going to temporary limited service at various headquarters to perform some useful duty; and at the same time to relieve them of the monotony of hospital life, pending the time that they can be returned to their parent hospitals and given whatever treatment they may need: further observation for possible surgery, or even if only for further board action to wind up their cases and to determine their final status. But in the directive that will come out having to do with the assignment of officer patients on such temporary limited service status, provisions will be made for the holding of patients in hospitals for further needs.

Now a word or two about some unrelated matters. Work Projects. Some hospitals have utilized very effectively so-called industrial therapy or work therapy. It is felt that such therapeutics be practiced as long as it is clear to the patient that the work which is prescribed is definitely work that will accomplish the desired purpose so far as the defect is concerned. In other words, I feel it is perfectly logical to have the patients in advanced reconditioning program do paint jobs. I am talking about outdoor paint jobs to recondition a weak arm or shoulder. We saw at one hospital several men working in the brace shop. These were men who had had injuries to the arms, shoulders and hands. Many of them had worn braces. Those men seemed to find a great deal of interest in working in the brace shop and assisting in the making of braces for others. In this

work they used a hack saw a great deal, and a rasp and file and other things which exercised their hands, arms and shoulders. In this particular brace shop there were 8 or 10 men, patients who had suffered dislocations to the shoulder or hands, or who had operations on elbows, or something of that sort. It was perfectly logical to those men that the work they were doing had a relationship to their particular defect. I bring these points out to illustrate the type of work that seems perfectly proper to describe. The motor and the tire shops have been utilized as sources of work therapy. Carpenter shops for men suffering from defects of hands, arms and shoulders, I think very important. In work therapy, the individual can clearly see that the work he is doing is related to his defects. It doesn't appear to me that patients should be called on to do onerous duties. I wouldn't put them on the garbage wagons or scrubbing floors. I think it is proper for them to take care of their ward or barracks and bathrooms adjacent, and work of that sort, but generally, I feel they should not be put on menial types of tasks.

There is one point I think we should all understand and that is that we do not want to try to set up from the Surgeon's office a certain type of facility. Every facility will necessarily be different from every other. The local conditions, the local community, will provide various types of help in one location which would not be possible in another. In setting up the program, it is most important to have initiative and imagination; one that can see the possibilities for utilizing local facilities, local talent, and local interest. Above all, there is one thing to remember; the primary purpose of your reconditioning program. Remember these people are patients, and you as doctors have the one responsibility. That is to do everything you can to hasten the recovery of the individual. We want the individual to have his morale built up. We want him to have the advantage of what education can be given him, but remember that the principal purpose of our reconditioning program is to restore the individual to health, and you must look on that as your primary purpose.

I think that a certain amount of publicity is desirable in connection with our reconditioning program. In the first place, it is worthy of publicity. Secondly, it is well for the populace, the mothers, fathers and wives of soldiers, to fully understand that this program is directed to the improved care of their loved ones in the service. We want to be careful that no one gets the idea that this is just a source of cheap labor around our hospitals. That is why I emphasize, and why it has been emphasized repeatedly in this program today, that the task which a man is assigned to do in the reconditioning program must be directly related to the defect which you are attempting to improve. Thank you very much.

COL. WILSON: The General's remarks should be very helpful to all of us. It seemed to me to be common sense and indicates a lot of practical experience. I am sure you will take his message home with you and use it to great advantage. As you might expect, the Surgeon General's office has been of a great deal of assistance to this office, Halloran General Hospital and England General Hospital staff in preparing this program. It was suggested by Colonel Thorndyke, Director of Reconditioning, that we should have a motion picture film by Capt. Sydney Licht, Physiotherapy and Occupational Therapy Officer, Lovell General Hospital, the subject being the relation of physical therapy to occupational therapy. I have heard a great deal about this film and look forward to seeing it.

COL. WALSON: Gentlemen, we are very much indebted to Col. Thorndyke for suggesting this picture on our program. I wonder if the author's script is available to circulate around to our hospital command. I will talk about that later.

The next picture which is very instructive, is Techniques of Physical Reconditioning, Special Service School, Lexington, Va., produced by Major Arthur A. Esslinger, Reconditioning Division, Office of The Surgeon General. The Major is not with us this evening, and Major Barton will explain this film to us.

MAJOR BARTON: I just want to introduce this film by a few remarks. Most patients in Class I and some in Class II training can profit by the use of TC 87, 1942 exercises. TC 87 represents the Army program of physical conditioning. The exercises have been well standardized. They have been carefully selected for a particular purpose. They are the best that can be assembled to produce physical conditioning. We would urge you to use these exercises on patients in Classes I and II. They have been worked out, until at the present time, it is possible to predict the result of the training in a given time for persons who choose conditioning as shown by taking a TC 87 test at the outset. It is possible to give your patients a set of exercises, establish a base line, give them training, and check their progress by means of the test. It is for this reason, that it is doubly useful to us. The forms are published at present only in texts in Special Service Schools. They are not generally available. We hope to make it available to you by authorizing it for distribution. The material will be a part of the new manual on physical exercises as it applies to reconditioning. The picture tells its own story so I won't have to make any more comments than these.